Emergency Medical Services Council

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Ambulance Medical Directors Subcommittee
Wednesday, February 28, 2018, 9:00 a.m. - 11:00 a.m.
Health Services Building, Room 111
525 Portland Avenue S., Minneapolis 55405

Draft Summary

Present	Absent
1. Jeffrey Ho, M.D., Hennepin EMS 2. Charlie Lick, M.D., Allina Health EMS 3. John Lyng, M.D., North Memorial Ambulance Service (by phone) 4. Paul Nystrom, M.D., Edina Fire Department 5. Kevin Sipprell, M.D., Ridgeview Ambulance Service (Chair)	
Guests	**Staff**
	1. Matthew R. Maxwell 2. Kristin Mellstrom

Welcome and Introductions – Chair Kevin Sipprell called the meeting to order at 9:05 a.m. with a quorum present. After introductions, the proposed February 28, 2018 agenda and meeting summary from November 8, 2017 were approved.

Administration of Magnesium Sulfate for Eclampsia – Sipprell explained that the recent addition of magnesium sulfate for eclampsia, added to the Adult Obstetrics Complications protocol, wasn't clear how the magnesium sulfate should be administered. The Subcommittee agreed each member should consult with pharmacy physicians at their respective hospitals to determine the most appropriate way to administer magnesium sulfate for eclampsia, and report back findings at the next Subcommittee meeting.

Medical Control Exam Revisions – Sipprell reminded the Subcommittee that at the October EMS Council meeting many of the lists in the protocol book (medication list, approved equipment and procedures list, etc.) were removed, rendering a significant number of questions on the medical control exam unanswerable. The Subcommittee temporarily suspended the medical control exam at its last meeting, and has been discussing how medical control testing should be conducted in the future.

The Subcommittee discussed whether the issue at hand is simply needing an improved methodology to train and test new medical control physicians (i.e. a new test), or if the root problem is an outdated medical control legacy system that no longer fits with the needs of the current EMS System. The Subcommittee agreed that, with sixteen medical control hospitals, close to three hundred certified medical control physicians, protocols trending away from medical control contact, and a diminishing quantity of medical control calls each year the end result is significant dilution of physician medical control experience and skills, which makes the current medical control structure prone to problems and failures.

The Subcommittee agreed the conversation should be a critical analysis of the current status of the medical control system, and discussion on what the optimal medical control system that streamlines patient care might look like. The Subcommittee recognized this issue is complex, and long-standing hospital concerns about patient disposition must be part of the conversation. The Subcommittee directed staff to investigate what type of medical control data is available and report back at the next meeting.

Trauma Disposition Guideline – Sipprell explained that the Medical Standards Committee remanded this back to the Subcommittee with direction to focus exclusively on major trauma. The Subcommittee briefly reviewed the current major trauma disposition guideline and agreed to the following changes (underline represents proposed language, strikeout represents proposed deleted language):

A. Ground ambulances must immediately transport patients with compromised airways (unable to maintain an airway and ventilate) to the nearest designated trauma hospital.
    - If no designated trauma hospital exists within 30 minutes transport time, the patient must be transported to the closest hospital.

B. In cases where a patient does not have a compromised airway, the ground ambulance must transport major trauma patients to a level I or level II trauma hospital within thirty minutes transport time.
    - If no level I or level II trauma hospital exists within 30 minutes transport time, the patient must be transported to the closest designated trauma hospital within 30 minutes transport time. If no designated trauma hospital exists within 30 minutes transport time, the patient must be transported to the closest hospital.

C. Major trauma defined as:
    1. Amputations (proximal to mid-hand or mid-foot or with other severe trauma)
    2. Crush injuries or prolonged entrapment/entanglement.
    3. Blunt trauma, multisystem, with Shock.
    4. Pelvic Fractures.
    5. Penetrating trauma to the eye(s), head, neck, chest, or abdomen, or extremity with shock.
    6. Maxillofacial trauma, Complex: including significant tissue avulsion, unstable/displaced facial or mandible fracture(s).
    7. Paralysis of a limb or limbs.

8. Traumatic Brain Injury, Severe (GCS less than 9)

D. ~~Other~~ Consider~~ations (in conjunction with significant trauma):~~ transport to a level I or level II trauma center for patients with significant trauma and any of the following:
   1. Severe multiple injuries (two or more systems) or severe single system injury
   2. Cardiac or major vessel injuries resulting from blunt or penetrating trauma
   3. Injuries with complications (e.g. shock, sepsis, respiratory failure, cardiac failure)
   4. Severe facial injuries
   5. Severe orthopedic injuries
   6. Co-morbid factors (e.g. Age < 5 or > 55 years, cardiac or respiratory disease, insulin-dependent diabetes, morbid obesity)
   7. Evidence of traumatic brain injury and/or spinal cord injury (e.g. new paralysis)
   8. Anticoagulation and bleeding disorders.
   9. Age
      - Older Adults (risk of injury death increases after 55 years).
      - Children (should be triaged preferentially to pediatric-capable trauma centers).
   10. Time sensitive extremity injury
   11. End-stage renal disease requiring dialysis
   12. Pregnancy > 20 weeks
   13. Paramedic provider impression is consistent with major trauma.

Stroke Disposition Guideline – Tabled pending update from the Brain Attack Coalition.

ED Crowding Position Paper – Tabled due to time constraints.

Review SMD Scene Response/Phone Calls (standing topic) – No items to discuss.

The meeting was **adjourned** at 10:40 a.m.